CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

Revised September 11, 2007

S. 1200
Indian Health Care Improvement Act Amendments of 2007

As ordered reported by the Senate Committee on Indian Affairs on May 10, 2007

SUMMARY

S. 1200 would authorize the appropriation of such sums as are necessary through 2017 for activities under the Indian Health Care Improvement Act, the primary authorizing legislation for the Indian Health Service (IHS). The bill also contains specific authorizations for a program to encourage Indians to pursue careers related to behavioral health, a demonstration project to provide suicide prevention services, a commission on Indian health care, and administrative costs for a new nonprofit corporation. Enacting the bill also would affect direct spending, primarily through provisions affecting the Medicaid program.

CBO estimates that implementing S. 1200 would have discretionary costs of $2.7 billion in 2008, about $16 billion over the 2008-2012 period, and about $35 billion over the 2008-2017 period, assuming appropriation of the necessary amounts. We also estimate that enacting the bill would increase direct spending by $9 million in 2008, $53 million over the 2008-2012 period, and $129 million over the 2008-2017 period.

S. 1200 would preempt state licensing laws in certain cases, and this preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA); however, CBO estimates that the costs of that mandate would be small and would not approach the threshold established in UMRA ($66 million in 2007, adjusted annually for inflation). The bill also would place new requirements on Medicaid that would result in additional spending of about $80 million over the 2008-2017 period. Those requirements, however, would not be intergovernmental mandates as defined by UMRA. Other provisions of the bill would benefit tribal governments by establishing new or expanding existing programs for Indian health care. This bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 1200 is summarized in Table 1. The costs of this legislation fall within budget function 550 (health).

TABLE 1. ESTIMATED BUDGETARY EFFECTS OF S. 1200

	By Fiscal Year, in Millions of Dollars				
	2008	2009	2010	2011	2012
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Estimated Authorization Level	3,257	3,326	3,402	3,481	3,558
Estimated Outlays	2,682	3,141	3,310	3,449	3,534
CHANGES IN DIRECT SPENDING[a]					
Estimated Budget Authority	9	10	11	12	12
Estimated Outlays	9	10	11	12	12

a. Direct spending changes through 2017 are shown in Table 3.

BASIS OF ESTIMATE

For the purpose of this estimate, CBO assumes that S. 1200 will be enacted near the start of fiscal year 2008 and that the necessary amounts will be appropriated for each year.

Spending Subject to Appropriation

The estimated effects of S. 1200 on spending subject to appropriation for the next five years are detailed in Table 2. Implementing the legislation would result in discretionary costs of about $16 billion over the 2008-2012 period. Because the bill would authorize funding through 2017, such discretionary cost would continue, with an estimated cost of about $35 billion over the 2008-2017 period.

TABLE 2. ESTIMATED EFFECTS OF S. 1200 ON DISCRETIONARY SPENDING

	By Fiscal Year, in Millions of Dollars					
	2007	2008	2009	2010	2011	2012
SPENDING SUBJECT TO APPROPRIATION						
IHS Spending Under Current Law [a]						
Budget Authority	3,169	0	0	0	0	0
Estimated Outlays	3,203	553	164	72	12	2
Proposed Changes:						
Existing Indian Health Service Activities						
Estimated Authorization Level	0	3,247	3,320	3,396	3,475	3,554
Estimated Outlays	0	2,679	3,134	3,303	3,443	3,529
Recruitment Program for Behavioral Health Careers						
Authorization Level	0	3	3	3	3	3
Estimated Outlays	0	2	3	3	3	3
Mental Health Demonstration Project						
Authorization Level	0	2	2	2	2	0
Estimated Outlays	0	*	1	2	2	1
Commission on Indian Health Care						
Authorization Level	0	4	0	0	0	0
Estimated Outlays	0	1	2	1	0	0
Native American Health and Wellness Foundation						
Authorization Level	0	1	1	1	1	1
Estimated Outlays	0	*	1	1	1	1
Total Changes						
Estimated Authorization Level	0	3,257	3,326	3,402	3,481	3,558
Estimated Outlays	0	2,682	3,141	3,310	3,449	3,534
Spending Under S. 1200						
Estimated Authorization Level [a]	3,169	3,257	3,326	3,402	3,481	3,558
Estimated Outlays	3,203	3,235	3,305	3,382	3,461	3,536

Note: * = less than $500,000.

a. The 2007 level is the amount appropriated for that year for IHS.

Existing Indian Health Service Activities. S. 1200 would authorize the appropriation of such sums as are necessary for the Indian Health Service through 2017. The agency's responsibilities under the bill would be broadly similar to those in current law. In 2007, the agency received an appropriation of $3.2 billion. CBO's estimate of the authorized level for IHS programs is the appropriated amount for 2007 adjusted for inflation in later years. (That level would grow to nearly $4 billion by 2017.) The estimated outlays reflect historical spending patterns for IHS activities.

Recruitment Program for Behavioral Health Careers. Section 105 of the bill would authorize the appropriation of $2.7 million annually through 2017 for grants to develop and maintain programs that encourage Indians to pursue careers in a field related to behavioral health. Assuming the appropriation of the authorized amounts, CBO estimates that implementing this provision would cost $2 million in 2008, $13 million over the 2008-2012 period, and $26 million over the 2008-2017 period.

Mental Health Demonstration Project. Section 708 would authorize the appropriation of $1.5 million annually for fiscal years 2008 through 2011 for grants to examine the feasibility of using telecommunication technology to provide suicide prevention services to Indians. Assuming the appropriation of the authorized amounts, CBO estimates that implementing this provision would cost less than $500,000 in 2008 and about $6 million over the 2008-2012 period.

Commission on Indian Health Care. Section 814 would authorize the appropriation of $4 million for a commission that would examine how the federal government provides health care services to Indians. The members of the commission would have to be appointed within eight months of the bill's enactment and would be required to submit a final report to the Congress no later than 18 months after that. Assuming the appropriation of the authorized amount, CBO estimates that implementing this provision would cost $1 million in 2008, $2 million in 2009, and $1 million in 2010.

Native American Health and Wellness Foundation. S. 1200 would establish a charitable and nonprofit corporation called the Native American Health and Wellness Foundation to assist federal, state, tribal, and other entities in efforts to further health and wellness activities and opportunities for Indians. The bill would authorize the appropriation of $500,000 annually for the foundation’s administrative expenses; this amount would be adjusted in later years for inflation. Assuming the appropriation of the authorized amounts, CBO estimates that implementing this provision would cost less than $500,000 in 2008 and about $2 million over the 2008-2012 period.

Direct Spending

S. 1200 contains several provisions, primarily related to the Medicaid program, that would affect direct spending. The bill's estimated effects on direct spending are shown in Table 3. Overall, CBO estimates that enacting the bill would increase direct spending by $9 million in 2008 and $129 million over the 2008-2017 period.

TABLE 3. ESTIMATED EFFECTS OF S. 1200 ON DIRECT SPENDING

	By Fiscal Year, in Millions of Dollars											
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
CHANGES IN DIRECT SPENDING												
Exemption from Medicaid Cost Sharing and Premiums												
Estimated Budget Authority	5	6	6	7	7	8	8	9	9	10	31	74
Estimated Outlays	5	6	6	7	7	8	8	9	9	10	31	74
Consultation with Indian Health Programs												
Estimated Budget Authority	*	*	1	1	1	1	1	1	1	1	3	7
Estimated Outlays	*	*	1	1	1	1	1	1	1	1	3	7
Medicaid Managed Care Provisions												
Estimated Budget Authority	3	3	4	4	4	5	5	5	6	6	18	45
Estimated Outlays	3	3	4	4	4	5	5	5	6	6	18	45
Scholarship and Loan Repayment Recovery Fund												
Estimated Budget Authority	*	*	*	*	*	*	*	*	*	*	2	4
Estimated Outlays	*	*	*	*	*	*	*	*	*	*	2	4
Total Changes												
Estimated Budget Authority	9	10	11	12	12	14	14	15	16	17	53	129
Estimated Outlays	9	10	11	12	12	14	14	15	16	17	53	129

Notes: Components may not sum to totals because of rounding.

* = costs or savings of less than $500,000.

IHS-funded health programs are commonly divided into three groups: those operated directly by the Indian Health Service, those operated by tribes and tribal organizations under self-governance agreements, and those operated by urban Indian organizations. For this estimate, they are referred to collectively as Indian health programs.

Exemption from Medicaid Cost Sharing and Premiums. Section 204 would prohibit Medicaid programs from charging premiums or other cost-sharing payments to Indians for services that are provided directly or upon referral by Indian health programs. The provision also would prohibit states from reducing payments to providers for those services by the amount of cost sharing that Indians otherwise would pay.

CBO anticipates that this provision's budgetary effect would stem largely from eliminating cost sharing for referral services. Current law already prohibits Indian health programs from charging cost sharing to Indians who use their services. In addition, Medicaid pays almost all facilities operated by IHS and tribes based on an all-inclusive rate that is not reduced to account for any cost sharing that Indians would otherwise have to pay. Finally, very few states charge premiums to their Medicaid enrollees.

Using Medicaid administrative data, CBO estimates that about 280,000 Indians are Medicaid recipients who also use IHS, and that federal Medicaid spending on affected services would be about $225 per person annually in 2008. The amount of affected spending would be relatively low because Medicaid already prohibits cost sharing in many instances, such as long-term care services, emergency services, and services for many children and pregnant women. For the affected spending, CBO assumes that cost-sharing payments by individuals equal 2 percent of total spending—Medicaid law limits the extent to which states can impose cost sharing—and that eliminating cost sharing would increase total spending by about 5 percent as individuals consume more services. Overall, CBO estimates that the provision would increase federal Medicaid spending by $5 million in 2008 and by $74 million over the 2008-2017 period.

Consultation with Indian Health Programs. Section 206 would encourage state Medicaid programs to consult regularly with Indian health programs on outstanding Medicaid issues by allowing states to receive federal matching funds for the cost of those consultations. Those costs would be treated as an administrative expense under Medicaid and divided equally between the federal government and the states. CBO anticipates that a small number of states would take advantage of this provision, increasing federal Medicaid spending by less than $500,000 in 2008 and by $7 million over the 2008-2017 period.

Medicaid Managed Care Provisions. Section 208 would make several changes to improve the ability of Indian health programs to receive payments for Indians who receive Medicaid benefits through managed care arrangements. Those changes include:

- Managed care organizations (MCOs) would have to pay Indian health programs at least the rates used for non-preferred providers. States also would have the option of making those payments directly to Indian health programs.

- MCOs would have to accept claims submitted by Indian health programs instead of requiring enrollees to submit claims personally.

- Some requirements that MCOs must now meet to participate in Medicaid would be waived or modified for Indian health programs that seek to operate as MCOs. (For example, MCOs run by Indian health programs would be able to limit enrollment to Indians only.)

- States would be required to offer contracts to Indian health programs seeking to operate their own MCOs.

Based on administrative data on Medicaid enrollment and spending for Indians who receive benefits via managed care, CBO estimates that those provisions would increase federal Medicaid spending by $3 million in 2008 and $45 million over the 2008-2017 period. We anticipate that the additional costs would be relatively modest because some states already use similar rules in their Medicaid managed care programs and Indian health programs would have a limited interest in participating as MCOs.

Scholarship and Loan Repayment Recovery Fund. S. 1200 would allow the Secretary of Health and Human Services to spend amounts collected for breach of contract from recipients of certain IHS scholarships. Under current law, those funds are deposited in the Treasury and not spent. Because the Secretary's ability to spend those funds would not be subject to appropriation, the provision would increase direct spending. Based on historical information from IHS, CBO estimates that the provision would increase spending by less than $500,000 a year, but would total about $4 million over the 2008-2017 period.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Intergovernmental Mandates

S. 1200 would preempt state licensing laws in cases where a health care professional is licensed in one state but is performing services in another state under a contract or compact with a tribal health program. This preemption would be an intergovernmental mandate as defined in the UMRA; however, CBO estimates that the loss of any licensing fees resulting from the mandate would be small and would not approach the threshold established in UMRA ($66 million in 2007, adjusted annually for inflation).

Other Impacts

S. 1200 would reauthorize and expand grant and assistance programs available to Indian tribes, tribal organizations, and urban Indian organizations for a range of health care programs, including prevention, treatment, and ongoing care. The bill also would allow IHS and tribal entities to share facilities, and it would authorize joint ventures between IHS and Indian tribes or tribal organizations for the construction and operation of health facilities. The bill would authorize funding for a variety of health services including hospice care, long-term care, public health services, and home and community-based services.

The bill would prohibit states from charging cost sharing or premiums in the Medicaid program to Indians who receive services or benefits through an Indian health program. CBO estimates that the new requirements in the bill would result in additional spending by states of about $80 million over the 2008-2017 period. Those requirements, however, would not be intergovernmental mandates as defined by UMRA because Medicaid provides states with significant flexibility to make programmatic adjustments to accommodate the changes. Some tribal entities, particularly those operating managed care systems, may realize some savings as a result of these provisions.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

This bill contains no private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATE

This estimate supersedes the cost estimate for S. 1200 that CBO transmitted on June 8, 2007. Our June 8 cost estimate erroneously indicated that section 204 of the bill (exempting Indians from paying certain types of cost sharing and premiums) would apply to both Medicaid and the State Children's Health Insurance Program. The provision would apply only to Medicaid, and we have lowered our estimate of the bill's impact on direct spending by $4 million over the 2008-2012 period and by $8 million over the 2008-2017 period as a result.

On September 11, 2007, CBO also issued a revised estimate for H.R. 1328, the Indian Health Care Improvement Act Amendments of 2007, as ordered reported by the House Committee on Natural Resources on April 25, 2007. There are only minor differences between the two bills, and CBO's revised estimates for them are identical.

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